

Equity and Social Determinants of Health

Summary: This project will bring to bear empirical evidence about the social determinants of health on conceptual work on equity in health and on policy implications.

Section: Ethics and Health Policy – Unit on Public Health

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Background: The discipline of bioethics was born in the clinic and in biomedical research. In the 1980s, as the numbers of Americans without health insurance became clearer and continued to grow, the extent of the failure to provide access to health care to all Americans became more widely appreciated. A relatively small minority of bioethicists then turned their attention to issues of justice or equity in the distribution of health care. Important though this work was, it had the significant shortcoming of focusing principally on health care, not health. This encouraged the assumption that differential access to health care is the principal inequity in the American health system and the principal cause of differences in health between individuals and groups. But differences in health across individuals and groups that are caused by social factors, and so are at least in principle within human and social control, are not primarily the result of differences in access to health care. The best estimate is that health care accounts for about one fifth of the socially caused variation in health. So if inequities in access to health care are of moral concern because they result in inequities in health, then focusing on health care is to miss most of the action on the real matter of concern—health.

Some other important determinants of health are the familiar staple of preventive medicine and public health-- individual behaviors such as high fat diets, lack of exercise, smoking and substance abuse that we know are risk factors for a variety of diseases. The specific concern of this project is with social factors, not these individual behaviors, which affect health and health inequalities; in particular, socioeconomic inequality and other social conditions such as education that are highly correlated with socioeconomic status. The effects of social conditions on health have long been a central focus of public health and this project will be a central component of the Department's newly established unit on public health. It is widely appreciated that poverty is associated with poor

health and decreased life expectancy. The differences are most dramatic in the international context where life expectancy in some very poor countries is no more than half that of many developed countries. The differences are less dramatic in the U.S. but persist—extreme poverty is bad for your health. But the effect of income differences in average health levels of countries tends to disappear when their per capita income reaches somewhere between \$5-10,000. In the advanced industrial countries there is no significant correlation between their per capita income and life expectancy. The material deprivation of extreme poverty adversely affects health and life expectancy, but beyond what in the U.S. is still a relatively low income increasing national wealth does not produce better health. There is little correlation between wealth and life expectancy in different states in the U.S. And other factors clearly have very large effects—per capita GDP in the U.S. is \$21,000 greater than in Costa Rica, but life expectancy is essentially the same. In other cases, countries with similar GDPs have very large differences in life expectancy—for example, life expectancy is 75.7 in Cuba but only 58.5 in Iraq, despite a roughly comparable level of wealth. Something beyond differences in wealth is at work.

There is controversy in the literature about the exact nature of the social gradient of health. One major social difference affecting health and life expectancy appears to be socioeconomic class. Socioeconomic differences in health and life expectancy exist in developed and less developed countries, and persist for treatable and untreatable diseases, for injuries, and after adjustment for differences in health behaviors. As one moves up the socioeconomic scale, there is a consistent increase in life expectancy. The first major, and still classic, study demonstrating this effect—the Whitehall study—found that as one went up grades in the British civil service there was a consistent increase in life expectancy, all in the absence of material deprivation at any grades. Moreover, the difference in life expectancy was not small—between the highest and lowest grades it was 4.4 years, greater than the entire effect of coronary disease. But many analysts have argued that it is not just where one stands in the socioeconomic hierarchy that affects health. It is also the degree of socioeconomic inequality in the society. A simple measure of the degree of inequality is the range of income distribution in the society. It appears that the greater a society's income inequality, other things equal, the worse the health and life expectancy of its citizens. This effect is significant enough that the life expectancy of lower classes in countries with low inequality can be higher than that of middle classes in equally wealthy countries with greater inequality. So there appear to be at least two important social determinants of health at work here—where one stands in the socioeconomic hierarchy affects one's health, and the degree of inequality in a society affects its overall level of health and the degree of health inequality in it.

Objectives:

1. To explore the implications of the social determinants of health for accounts of health, as opposed to health care, equity.

2. To explore the implications for social policy of health inequalities caused by inequalities in the social determinants.

Methodology: This project is at a beginning stage of development, but it is already clear that it will have both conceptual and empirical components. The conceptual components will involve articulating and critically evaluating normative arguments about health equity and integrating them with broader work in distributive justice that addresses the social determinants that affect health. The project will draw on the burgeoning empirical literature on the social determinants of health, but is not expected to involve original empirical studies of those determinants. The aspect of the project that involves the implications for social policy of the social determinants of health will involve a weaving of conceptual and policy analysis.

Results: This project is just beginning to be defined and while we have some background publications bearing on it, direct results are not yet available.

Future Directions: We intend to explore the implications of this social determination of health and health inequalities for bioethics. Little work has been done on this question and the answer is by no means clear. What is clear is that the question is important and needs more attention. These are not inevitable health inequalities about which we can do nothing. They are caused by social inequalities that are at least largely within our control. And the recent trends in the U.S. of widening economic inequality can be expected only to increase the health inequalities.

One issue raised by this social determination of health inequalities is what the proper account of health equity is. What inequalities in health are unjust? What is the distributive goal at which justice in health should aim? This is a good deal less clear than it might seem. It bears on the controversies about how to measure health inequalities that have surrounded recent WHO work on health inequalities as part of its assessment of the effectiveness of health care systems. Contrary to what might be thought the goal is not equality in health. That goal is subject to what Derek Parfit called the “leveling down” objection. There would be nothing good about achieving equality in health by worsening the health of the healthy. Virtually all theories of justice hold that some socioeconomic inequalities are not unjust, whereas others are unjust. Suppose we assume we have an account of which socioeconomic inequalities are unjust, and could determine the degree or proportion of health inequalities that they cause. Presumably, those health inequalities are unjust because the worse health caused to those of low socioeconomic status by unjust socioeconomic inequalities only compounds the initial socioeconomic injustice. But this relation may be more complex. It is an open question whether we can determine which socioeconomic inequalities are

unjust independent of any consideration of their effects on health. Most theories of justice appear to assume this, but it may be mistaken. For example, Rawls's Difference Principle permits socioeconomic inequalities to the extent that they improve the expectations of the least advantaged representative group, and the assumption is that it is the socioeconomic position of that group that is in question. If we have an independent account of health equity, then to the extent that inequalities that satisfy the Difference Principle cause inequities in health, the justice of those socioeconomic inequalities is called into question. In effect, we would face a tradeoff between socioeconomic benefits and health. How that tradeoff should be made is far from clear, but some otherwise justified socioeconomic inequalities might be all things considered unjust because of the unjust health inequalities they cause. However, until we have a clear account of health equity it will not be possible to assess this tradeoff, and it is plain that we do not have a clear account of health equity.

At the policy level, several countries such as Great Britain and Sweden have begun to explore the implications for social policy beyond the health care system of the social determination of health. For example, in Great Britain the Independent Inquiry into Inequalities in Health (known as the Acheson report) examined the implications for health and health inequality of a wide range of social policy including income and taxes, education, employment, housing and environment, transportation, nutrition and policies aimed at specific age groups. However, little systematic attention has been given to these implications for public policy in the U.S. We plan to pursue comparable questions for social policy in the U.S.

Publications:

Dan W. Brock, "Broadening the Bioethics Agenda", Kennedy Institute of Ethics Journal, 10 (2000) 21-38.

Ethical Dimensions of Health Policy, eds. M. Danis, C. Clancy and L. Churchill. New York: Oxford University Press, 2002.